MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
WIC AND NUTRITION SERVICES

MEDICAL DOCUMENTATION - HEALTH CARE PROVIDER AUTHORIZATION
FOR SPECIAL FORMULAS AND WIC SUPPLEMENTAL FOOD

Medical documentation is federally required to ensure that the patient under your care has a medical condition that requires the use of special formula and that conventional foods are precluded, restricted, and inadequate to meet their special nutritional needs.

INSTRUCTIONS: COMPLETE SECTIONS A AND D FOR ALL PATIENTS.

- To request a special formula and supplemental foods, also complete section B.
- To request a soy beverage, tofu or additional cheese, also complete section C.

The Missouri WIC Program will not authorize issuance for:

- Non specific symptoms; such as intolerance, fussiness, gas, spitting up, constipation or colic.
- Enhancing nutrient intake or managing body weight without any underlying medical condition.

Fax form to WIC clinic or have WIC participant return form to clinic.

LOCAL AGENCY

PHONE

FAX

A. PATIENT INFORMATION (COMPLETED BY PHYSICIAN OFFICE STAFF)

PATIENT'S NAME (LAST, FIRST, MI) | DOB

PARENT/CAREGIVER'S NAME | HEIGHT | WEIGHT | HGB

Medical Reason/Dx:
(Qualifying Condition)
**MO WIC Risk Factor eligibility in parenthesis.*

☐ Prematurity *(*RF 142)*	☐ Low Birth Weight *(*RF 141)*	☐ Failure to Thrive *(*RF 134)*	☐ Metabolic Disorders
☐ Gastrointestinal Disorders *(*RF 342)*	☐ Malabsorption Syndromes *(*RF 341)*	☐ Immune System Disorder *(*RF 360)*	☐ Severe Food Allergy *(*RF 353)*

☐ Other-Describe (Life Threatening Disorders, Diseases and Medical Conditions that impair digestion, absorption, or utilization of nutrients that could adversely affect the participants nutrition status). *(*RF 341-362)*

APPROVAL LENGTH
☐ 1 MONTH ☐ 2 MONTHS ☐ 3 MONTHS ☐ 4 MONTHS ☐ 5 MONTHS ☐ 6 MONTHS (MAX)

B. SPECIALTY FORMULA AND WIC SUPPLEMENTAL FOODS (COMPLETED BY PHYSICIAN OFFICE STAFF)

FORMULA REQUESTED (SEE LISTED ON BACK)

PRESCRIBED AMOUNT
☐ MAXIMUM ALLOWABLE **OR** ☐ _____ OZ/DAY

SPECIAL INSTRUCTIONS/MIXING FOR FORMULA REQUESTED

SUPPLEMENTAL FOOD (CHECK ONE)
☐ Issue full provision of age appropriate supplemental foods.
☐ No WIC supplemental foods; provide formula only.
☐ Issue a modified food package omitting the supplemental foods checked below.

SPECIAL INSTRUCTIONS FOR SUPPLEMENTAL FOOD

WIC PARTICIPANT CATEGORY	WIC SUPPLEMENTAL FOODS (CHECK FOOD TO OMIT)
Infants (6-11 mos)	☐ Infant Cereal ☐ Infant Fruits/Vegetables
Children (1-4 yrs) **& Women**	☐ Milk* ☐ Cheese ☐ Peanut Butter ☐ Eggs ☐ Legumes ☐ Breakfast Cereals ☐ Juice ☐ Whole Grains ☐ Fruits & Vegetables ☐ Fish (fully breastfeeding women only)

*WIC provides low fat milk for women and children > 2 years of age. Whole milk may be issued only to patients receiving specialty formula whose medical condition qualifies them. Only whole milk will be issued to 1 year olds.

C. SOY BEVERAGE, TOFU OR ADDITIONAL CHEESE (COMPLETED BY PHYSICIAN OFFICE STAFF)

CHECK THE BOXES BELOW TO PRESCRIBE SOY BEVERAGE, TOFU OR ADDITIONAL CHEESE. *NOTE: CHEESE, TOFU AND SOY BEVERAGE AMOUNTS WILL BE DEDUCTED FROM THE MAXIMUM MONTHLY ALLOWANCE FOR REDUCED/LOW-FAT MILK, BASED ON PARTICIPANT CATEGORY.*

☐ Soy Beverage or Tofu for Children
☐ >1 lb Cheese for Women or Children
☐ >4 lbs Tofu for Women (Prenatal and Partially or Non-Breastfeeding)
☐ >6 lbs Tofu (for fully Breastfeeding Women)

DIAGNOSIS (REQUIRED). *PERSONAL PREFERENCE IS NOT AN ALLOWED REASON.*
☐ Milk Allergy ☐ Severe Lactose Maldigestion ☐ Vegan Diet

D. HEALTH CARE PROVIDER INFORMATION (COMPLETED BY PRESCRIPTIVE AUTHORITY LICENSED BY THE STATE)

SIGNATURE OF HEALTH CARE PROVIDER | DATE

PROVIDER'S NAME (PLEASE PRINT) ☐ MD ☐ DO ☐ PA ☐ NP | PHONE NUMBER

MISSOURI WIC PROGRAM

APPROVED FORMULAS LISTING

STANDARD CONTRACT INFANT FORMULAS

These formulas will be given unless a physician diagnoses a medical condition that warrants a specialty formula.

- No prescription is needed for infants to receive: ***Enfamil Premium, Enfamil LIPIL with Iron, Enfamil Prosobee Lipil/Enfamil Soy, or Gentlease LIPIL.**
- A prescription is needed for adults and children over one year of age and is valid for up to six (6) months.

SPECIALTY FORMULAS FOR INFANTS

Medical documentation is required for issuance of these formulas.

Reasons such as "colic," "spitting up," or "constipation" will NOT be accepted as a substitute for a medical diagnosis.

Elecare*
Elecare DHA/ARA*
EnfaCare LIPIL (22 cal)*
Enfamil A.R. LIPIL*
Enfamil Human Milk Fortifier
Enfamil LIPIL w/Iron (20 cal) non-premature (Nursette)
Enfamil LIPIL w/Iron (24 cal) non-premature (Nursette)
Enfamil Premature LIPIL with Iron (20 cal) (Nursette)
Enfamil Premature LIPIL with Iron (24 cal) (Nursette)
Enfaport LIPIL
NeoCate Infant Formula*
NeoCate Infant Formula DHA/ARA*
Nutramigen AA*
Nutramigen LIPIL with Enflora LGG*
Pregestimil LIPIL*
Pregestimil LIPIL (20 cal) *(Nursette)
Pregestimil LIPIL (24 cal) *(Nursette)
Similac Alimentum*
Similac NeoSure (22 cal)*
Similac PM 60/40*
Similac Special Care w/Iron (20 cal) (Nursette)
Similac Special Care w/Iron (24 cal) (Nursette)

The * indicates that the formula can also be issued to children whose medical condition qualifies them.

SPECIALTY FORMULAS FOR WOMEN AND CHILDREN

Women	Children		
Al Soy	Boost Kid Essentials-All Flavors	Ketocal	Peptamen Jr.-All Flavors
Boost-All Flavors	Boost Kid Essentials 1.5 cal-All Flavors	NeoCate Junior-All Flavors	Petamen Jr. 1.5
Ensure-All Flavors	Boost Kid Essentials with Fiber 1.5 cal Vanilla	NeoCate One + Powder	Peptamen Jr. Powder (Vanilla)
Ensure-Vanilla	Bright Beginnings Soy Pediatric Drink	Nutren Junior-Vanilla	Peptamen Jr. with Fiber
Peptamen-All Flavors	Enfagrow Gentlease	Nutren Junior with Fiber-Vanilla	Peptamen Jr. with Prebio
Peptamen with Prebio	Enfagrow Premium (Enfamil Next Step LIPIL)	Pediasure-All Flavors	Portagen**
Peptamen 1.5-All Flavors	Enfagrow Soy (Enfamil Next Step Soy LIPIL)	Pediasure Enteral	Suplena**
Tolerex	E028 Splash-All Flavors	Pediasure with Fiber-Vanilla	
Vivonex T.E.N.	**The ** indicates that the formula can also be issued to women whose medical condition qualifies them.**		

For complete listing of WIC Approved Formulas & Supplemental Food refer to http://www.dhss.mo.gov/wic/FoodPackages/InfoforHealthCareProviders.html.

WIC USE ONLY - MUST COMPLETE SECTION IN ITS ENTIRETY.

PARTICIPANT'S NAME

STATE WIC ID

REASON(S) FOR REQUESTING READY-TO-USE/FEED (RTU/RTF)

☐ Poor Water Quality ☐ Tube Feeding ☐ Poor Refrigeration
☐ Product only available in RTU/RTF ☐ Better accommodates the participants condition ☐ Mixing/Dilution Difficulty
☐ Improves the participants compliance in consuming the product

☐ **APPROVED** ☐ **DISAPPROVED**

IF DISAPPROVED, WAS HEALTH CARE PROVIDER (HCP) CONTACTED? ☐ YES ☐ NO

DID HCP AGREE TO SUGGESTED CHANGES? ☐ YES ☐ NO

MONTH(S) APPROVED

☐ Jan ☐ Feb ☐ Mar ☐ Apr
☐ May ☐ Jun ☐ July ☐ Aug
☐ Sept ☐ Oct ☐ Nov ☐ Dec

QUESTIONS/CONCERNS/CHANGES

DOES THIS APPROVAL EXTEND BEYOND THE CURRENT CERTIFICATION?

☐ YES ☐ NO IF YES, SET AN ALERT FOR REMAINING APPROVAL PERIOD.

CHEESE AMOUNT APPROVED	TOFU AMOUNT APPROVED	PRIMARY MILK AMOUNT APPROVED	SOY BEVERAGE AMOUNT APPROVED

APPROVED BY ☐ RD ☐ Nutritionist ☐ RN

DATE

AGENCY NAME

AGENCY NUMBER

COMPLETE THIS SECTION WHEN LWP RECEIVES APPROVAL FROM THE STATE OFFICE

NAME OF STATE NUTRITIONIST

☐ Approval Letter on File

DATE APPROVED

LOCAL WIC PROVIDER – SCAN COMPLETED DOCUMENT IN MOWINS